

Utilization Management (UM): A Primer

What is UM?

The primary function at the health plan level to manage resources is utilization management. The purpose of utilization management is to maximize the quality of services provided while effectively managing resources and ensuring uniformity of benefits for all eligible beneficiaries. As benefit managers for specialty behavioral health supports and services in the State of Michigan, PIHPs and CMHs have an obligation to ensure that Medicaid beneficiaries who need services and supports related to behavioral health conditions can access services in adequate amount, scope, and duration to address their needs.

The *need* referenced here relates specifically to “medical necessity” for specific services. Services for which individuals do not meet medical necessity criteria may not be funded with Medicaid dollars. Michigan’s Medicaid Provider Manual¹ defines Medical Necessity for Specialty Behavioral Health benefits as:

- Necessary for screening and assessing the presence of a mental illness, co-occurring disorders and/or
- Required to identify and evaluate a mental illness, co-occurring disorders; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, co-occurring disorders; and/or
- Expected to arrest or delay the progression of a mental illness, co-occurring disorders; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Managed care systems use established medical necessity criteria to ensure that beneficiaries' services align with their medical and/or behavioral needs.

Utilization Management Defined:

Utilization management typically includes the following functions:

- 1) access and eligibility determination
- 2) utilization management protocols
- 3) service authorization
- 4) utilization review

Utilization Management (UM) is a set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the application of written policies and procedures, Utilization Management is designed to ensure:

- that only eligible beneficiaries receive specialty plan benefits
- that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires
- that beneficiaries are linked to other Medicaid, Health Plan or other services when necessary

The purpose of UM is to identify, monitor, evaluate, and resolve issues that may result in inefficient delivery of care or that may have an impact on resources, services, and consumer outcomes.

UM is accomplished through:

- Access and Eligibility Determination
- Level of Care/Service Authorization Guidance
- Authorization (prospective, concurrent, retrospective)
- Utilization Review
- Care Management

Utilization Review typically focuses on:

- LOC Determination
- Application of Service Selection Criteria
- Application of Best Practice Guidelines

Who is required to perform UM functions?

Per the MDHHS PIHP Contract:

The PIHP shall assure that customers located in the service area have clear and identifiable access to needed supports and services when they are needed, and that supports and services are of high quality and delivered according to established regulations, standards, and practice guidelines. The PIHP shall also perform utilization management functions sufficient to control costs and minimize risk while assuring quality care.

PIHPS are allowed to partially or fully delegate some functions to their provider networks¹.

The MDHHS PIHP contract states the PIHPs have a responsibility to analyze claims and encounter data to understand region-wide and CMHSP-specific service utilization. MDHHS expects the PIHP to use this information to inform risk management strategies and other health plan functionsⁱⁱ. Even in a centralized UM model, the CMHSP always has a critical role to play in ensuring appropriate clinical service delivery.

Why is UM necessary?

The simplest answer is to ensure the right service is provided at the right time in the right amount. To do this, the PIHP needs to equitably meet the needs of everyone in the region with common resources.

A level-of-care system, or service authorization guidelines, is one method for attempting to address the challenge posed by the *tragedy of the commons* in healthcare. Put briefly, the *tragedy of the commons* describes a scenario where multiple individuals are each using a common resource in a way that makes sense for themselves, yet where the combined use of all individuals outpaces the available resources for the populationⁱⁱⁱ. This issue underlies many of the challenges related to American healthcare's infamous cost-curve, which is receiving increased attention through efforts to reduce the collective harm of overuse^{iv}.

This responsibility is acknowledged by the *MDHHS Medicaid Provider Manual*, Section 17.2, which states that:

"Decisions regarding the authorization of a B(3) service (including the amount, scope and duration) must take into account the PIHPs documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B(3) supports and services are not intended to meet all the individuals needs and preferences, as some needs may be better met by community and other natural supports."

Compliance with Federal Regulations

Health plans must demonstrate compliance with the MDHHS/PIHP contract requirements and 42CFR 440.230(d), which provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

In addition, Home and Community Based Waiver Rules^v require that service providers demonstrate freedom from conflict of interest and maintain firewalls^{vi1} between the assessment, authorization decision & service delivery. In an ideal scenario, Conflict-Free Case Management (CFCM) complements the goal of improving person-centered planning while also serving as part of an effective cost-containment strategy. Through the development of firewalls that separate the distinct functions of assessment, authorization, planning and service provision, case managers are better able to objectively support and assist consumers in identifying needs and developing plans to access services.

ⁱ https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html

ⁱⁱ For addition information about PIHP UM Plan requirements see Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 – Attachment P7.9.1

ⁱⁱⁱ See, for instance, the state of Washington's Choosing Wisely program, documented in First, Do No Harm: Calculating Health Care Waste

^{iv} The phenomenon was first noted and researched with regard to ecological resources, yet the extension to financial resources is a logical one and economic strategies to address the tragedy of the commons won Elinor Ostrom the Nobel Prize in Economics.

^v 42 CFR 441.301(c)(1)(vi)

^{vi} For additional information about Conflict Free Case Management see “Conflict Free Case Management: Federal Guidance, State Engagement, and Impacts”, retrieved from <https://www.tbdsolutions.com/papers-presentations-2/>